

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH		MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH		
County <u>Harrison</u>		Registration District No. <u>341</u>	File No. <u>22494</u>	
Township _____ or Village _____		Primary Registration District No. <u>4204</u>	Registered No. <u>7</u>	
City <u>Ridgeway</u> , (NO. _____) St.: _____ Ward _____		(If death occurred in a hospital or institution, give its NAME instead of street and number)		
FULL NAME <u>Vernal Gerald Stanley</u>				
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE <u>Single</u> MARRIED _____ WIDOWED _____ OR DIVORCED _____ (Write the word)	DATE OF DEATH <u>July - 23 - 1914</u> (Month) (Day) (Year)	
DATE OF BIRTH <u>June 11, 1912</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>July 22, 1914</u> , to <u>July 23, 1914</u> , that I last saw him alive on <u>July 23, 1914</u> and that death occurred, on the date stated above, at <u>2:30 P.M.</u>	
AGE <u>2</u> yrs. <u>2</u> mos. <u>1</u> ds. IF LESS than 1 day, _____ hrs. or _____ min.?			The CAUSE OF DEATH* was as follows: <u>Septicemia</u>	
OCCUPATION (a) Trade, profession, or particular kind of work <u>Harmon</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____			(Duration) _____ yrs. _____ mos. <u>10</u> ds.	
BIRTHPLACE (City or town, State or foreign country) <u>Ridgeway</u>			Contributory <u>Slight injury to arm</u> (SECONDARY) (Duration) _____ yrs. _____ mos. <u>10</u> ds.	
PARENTS	NAME OF FATHER <u>Art Stanley</u>		(Signed) <u>Lorne Brewer</u> M. D.	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Ridgeway</u>		<u>July 24, 1914</u> (Address) <u>Ridgeway, Mo</u>	
	MAIDEN NAME OF MOTHER <u>Etta Beins</u>		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Mt. View</u>		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE				
(Informant) <u>Arthur Stanley</u>			Where was disease contracted if not at place of death? _____	
(ADDRESS) <u>Ridgeway Mo</u>			Former or usual residence _____	
Filed <u>July 24, 1914</u> <u>Lorne Brewer</u> REGISTRAR			PLACE OF BURIAL OR REMOVAL <u>Ridgeway Cemetery</u>	
			DATE OF BURIAL <u>July 24, 1914</u>	
			UNDERTAKER <u>O.P. Rogan</u> <u>San</u> ADDRESS <u>Ridgeway Mo</u>	

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sar-*

coma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)



WITH UNFADE INK - THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH

County Harrison

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Township Ridgeway
or
Village
or
City

Registration District No. 341 File No. _____

Primary Registration District No. 4204 Registered No. 7

(NO. _____) St. _____ Ward _____

FULL NAME Vernal G Stanley

(If death occurred in a hospital or institution, give its NAME instead of street and number)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX M COLOR OR RACE W. SINGLE MARRIED WIDOWED OR DIVORCED Single
(Write the word)

DATE OF DEATH 7 / 23 1914
(Month) (Day) (Year)

DATE OF BIRTH Satisfactory Information Supplied
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw him on _____, 191____, and that death occurred, on the _____ stated above, at _____ m.

AGE _____ yrs. _____ mos. _____ ds. If LESS than day, hrs. min.

The CAUSE OF DEATH* was as follows: Satisfactory Information Supplied.

OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____

Septicemia - Arteriosclerosis
with injury of arm - open
with infection
Duration _____ yrs. _____ mos. _____ ds.

BIRTHPLACE (City or town, State or foreign country) _____

Contributory (SECONDARY) Slight Injury to Arm
Duration _____ yrs. _____ mos. _____ ds.

NAME OF FATHER _____

BIRTHPLACE OF FATHER (City or town, State or foreign country) _____

MAIDEN NAME OF MOTHER _____

BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

(Signed) John Brewer M.D.
July 24, 1914 (Address) Ridgeway Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place _____ yrs. _____ mos. _____ ds. In the _____ State _____ yrs. _____ mos. _____ ds.

(Informant) _____

Where was disease contracted If not at place of death? _____

(ADDRESS) _____

Former or usual residence _____

FILED Aug 31 1914 John Brewer REGISTRAR

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191____

UNDERTAKER _____ ADDRESS _____
Satisfactory Information Supplied

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[Approved by U. S. Census and American Public Health Association]

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